

Contract Number Request Form
SOUTHERN REGION

1. Contract Manager:	Seymour Brown
2. Provider Name:	National Mentor Healthcare, LLC
3. Service to Be Provided:	Residential Habilitation, Adult Day Training & Transportation
4. Method of Procurement	Regulated Exemption - HPM
Competitively Procured?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<i>If Yes, type of Procurement and Number</i>	
Non-Competitively Procured?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<i>If Yes, type of Exemption and attach CF1117</i>	
5. Contract Term	
Begin Date:	July 1, 2010
End Date:	June 30, 2013
6. Contract Amount:	\$276,174.00
7. Contract Number:	KL591



agency for persons with disabilities
State of Florida

DOCUMENTATION FOR USE OF REGULATED EXEMPTION METHOD OF PROCUREMENT

Contract #: KLJ91

National Mentor Healthcare, LLC/ dba Florida Mentor

☒ Client

☐ Non-Client

1. Describe the services to be provided. Explain what comprises a service unit and how many units, by type of service, will be provided under the contract.

The services to be provided are Adult Day Training (ADT), Residential Habilitation (Res. Hab.) and Transportation.

A unit of ADT service is defined as one day (minimum of six hours) of actual time spent in the ADT program per Client. ADT services are classified under various ratios depending on client/ staff needs. Approximately 756 units of service will be provided under this contract.

A unit of Res. Hab. service is defined as one Client receiving Res. Hab. services for one day.

Approximately 1,245 units of residential habilitation service will be provided under this contract.

A unit of Transportation service is defined as one Client receiving one month of transportation service.

Approximately 36 units of transportation service will be provided under this contract.

2. This service is classified as a "Regulated Exemption" defined as [reference CFOP 75-2, Chapter 4]:

Underline one: IGA HPM LES MPD LAW REA PRE HPM

3. Explain how the service to be provided fits the Exemption classification used above.

Services are being rendered by a Florida For Profit Corporation to Clients with health related issues.

4. Explain why formal competitive purchasing practices (RFP/ITN/ITB) were not practical and/or in the best interest of the department. State the situation necessitating the use of noncompetitive procedures.

Clients and their family members along with their respective Case Managers/ Support Coordinators selected the Provider of choice consistent with Agency Coordination Guidelines. Additionally, the rate for the services to be rendered compares favorably with the Agency Medicaid Waiver rates.

5. Explain what action was taken to be competitive to the greatest extent possible. (Continuation with a historical provider must be explained.)

See Section 4 above.

6. Explain the reasons for selection (including name of provider selected for this service) and why this selection represents the most advantageous decision for the state in terms of service and price. If this is the only provider willing or able to provide these services, state how this was determined.

See Section 4. above.

7. Identify names of individuals taking part in the development or selection of evaluation criteria.

Evelyn Alvarez -- Area 11 Administrator, Maria Springer -- Program Operations Administrator, Miriam Collazo -- Budget Manager, Kirk Ryon -- Program Operations Administrator and Seymour Brown -- Contract Manager

8. Identify names of individuals taking part in the evaluation of the provider's response and provider

selection.


See Section 7 above.

Conflict of Interest Questionnaires have been completed by all individuals named in items 7 and 8.

Yes

Approvals:

Contract Manager:

 5/5/10
(Date Signed)

Contract Signer:

(Date Signed)



MEMORANDUM OF NEGOTIATION

National Mentor Healthcare, LLC d/b/a Florida Mentor
#KLJ91

I. Introduction

A. Participants:

Agency Staff
Evelyn Alvarez
Miriam Collazo
Maria Springer
Kirk Ryon
Seymour Brown

Provider Staff
Estrella Granda

B. Meeting Date(s): 04/22/10

C. Meeting Location: 401 NW 2nd Ave. – S811, Miami, FL33128 (Meeting was conducted by phone).

II. Procurement History

Services to be provided under this contract will be non-competitively procured. Provider has an existing contract, KLJ64, with the Agency to provide regular residential habilitation, behavior focus residential habilitation and companion services to developmentally disabled Clients who do not qualify for services under the Medicaid waiver programs. This contract will expire on 06/30/10. The services provided under the existing contract have been satisfactory.

III. Narrative Summary of the Negotiations

The issues negotiated are as indicated below:

- Residential Habilitation and companion services shall be provided to two Area 11 Clients based on the needs documented on the Clients' Support Plan and approved by the Agency. Additional Clients may be added if approved by the Agency.
- Agency approval shall be granted through an Agency approved Client Authorization Form to be completed by the Clients' Case Managers or Support Coordinators and approved by their Supervisors, Budget Manager and Contract Manager.
- Rates shall remain at the same levels on the existing contract, KLJ64.
- Staff levels- Provider shall maintain suitable and qualified staff sufficient to meet the needs of the Clients to be served.
- Professional Qualification- Requirements remain the same as the existing contract, KLJ64.
- Service Locations- Services will be provided at Clients' place of residence and within the Miami-Dade County community.
- Report requirements will remain at the levels required on the existing contract, KLJ64.
- Provider may be monitored annually by the Contract Oversight Unit.
- The value of the contract will be a maximum of \$92,058.00 annually, subject to the availability of funds and the delivery of services.
- The contract duration is July 1, 2010 through June 30, 2013.

IV. Discussion of Additional Information Required to Proceed

It was further agreed that the Provider would review the new Standard Contract and notify the Contract Manager of any concerns prior to the signing of the new contract.

V. Conclusion

It was agreed that an optional renewable clause allowing the contract to be extended for up to a maximum of an additional two years would be included in the contract. This is contingent on satisfactory performance from the Provider and the availability of state or federal funds.

VI. Signatures:

Shirley D. Shandall, MHA
Signature by provider's representative

[Signature]
Signature by Agency's lead negotiator

Title: Regional Director

Title: Contract Manager

Date: 5/7/10

Date: 5/7/10

Note: The agreements outlined above occur after negotiations and **PRIOR** to preparation of the Contract document.

FLORIDA SINGLE AUDIT ACT CHECKLIST FOR NON-STATE ORGANIZATIONS - RECIPIENT/SUBRECIPIENT VS. VENDOR DETERMINATION

This checklist and the standard contract audit language may be obtained electronically from the Department of Financial Services' website (<https://apps.fldfs.com/fsaa>).

If a Florida Single Audit Act State Project Determination Checklist has not been previously completed, please complete it now. (Applies only to State agencies)

This checklist must be used by State agencies to evaluate the applicability of the Florida Single Audit Act (FSAA) to non-state organizations¹ after a state program has been determined (using the Florida Single Audit Act State Project Determination Checklist) to provide state financial assistance (i.e. is a State Project as defined in 215.97 (2)(r), F.S.). This checklist assists in determining if the non-state organization is a vendor, recipient/subrecipient, or an exempt organization.

¹ A non-state organization is defined as a nonprofit organization, for-profit organization (including sole proprietors), or Florida local government (excluding district school boards, charter schools and community colleges), which receives State resources.

Recipients and subrecipients of state financial assistance must also use this checklist to evaluate the applicability of the FSAA to non-state organizations to which they provide State resources to assist in carrying out a State Project.

Name of Non-state Organization: National Healthcare, LLC/ d/b/a Florida Mentor

Type of Non-state Organization: for-profit

(i.e. nonprofit, for-profit, local government; if the non-state organization is a local government, please indicate the type of local government – municipality, county commission, constitutional officer, water management district, etc.)

Awarding Agency: APD

Title of State Project: Residential Habilitation

Catalog of State Financial Assistance (CSFA) Number: _____

Contract/Grant/Agreement Number: KLJ91

PART A

YES	NO	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	1. Is the non-state organization a district school board, charter school, community college, government/public university outside of Florida or a Federal agency?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. Is the relationship with the non-state organization only to procure commodities (as defined in 287.012(5) F.S.)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3. Does the relationship with the non-state organization consist of only Federal resources, State matching resources for Federal Programs or local matching resources for Federal Programs?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	4. Does the relationship with the non-state organization consist of only State maintenance of effort (MOE) ² resources that meet all of the following criteria?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	A. Do Federal Regulations specify the requirements for the use of the State MOE resources and are there no additional State requirements?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	B. Do contracts contain sufficient language to identify the State MOE resources and the associated Federal Program?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	C. Do A-133 audit requirements apply to the State MOE resources and do contracts stipulate that the State MOE resources should be tested in an A-133 audit in accordance with Federal Program requirements?

² MOE refers to the Federal maintenance of effort/level of effort requirements as defined by OMB Circular A-133 Compliance Requirement G (Matching, Level of Effort, Earmarking).

If any of 1-4 above is **yes**, the recipient/vendor relationship determination does not need to be completed because the FSAA is not applicable to the non-state organization.

PART B

Recipient/Vendor Relationship Determination:

The following should be analyzed for each relationship with a non-state organization where it has been determined that the state program provides state financial assistance (i.e. is a State Project) and the non-state organization is not exempt based on the questions above. This relationship may be evidenced by, but not limited to, a contract, agreement, or application.

YES NO

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 1. Does State law or legislative proviso create the non-state organization to carry out this State Project? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 2. Is the non-state organization required to provide matching resources not related to a Federal Program? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 3. Is the non-state organization required to meet or comply with specified State Project requirements in order to receive State resources? (State Project requirements include laws, rules, or guidelines specific to the State Project such as eligibility guidelines, specified types of jobs to be created, donation of specified assets, etc. Specified State Project requirements do not include procurement standards, general guidelines, or general laws/rules.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 4. Is the non-state organization required to make State Project decisions, which the State agency would otherwise make? (e.g. determine eligibility, provide case management, etc.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 5. Is the non-state organization's performance measured against whether State Project objectives are met? (e.g. number of jobs to be created, number of patients to be seen, number of disadvantaged citizens to be transported, etc. Performance measures may or may not be related to State performance-based budgeting.) |

If any of the above is **yes**, there is a **recipient/subrecipient relationship** and the non-state organization is subject to the FSAA. Otherwise the non-state organization is a **vendor** and is **not** subject to the FSAA.

PART C

Based on your analysis of the responses above and discussions with appropriate agency personnel, state your conclusion regarding the non-state organization:

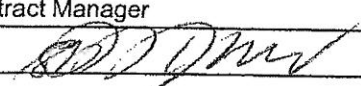
(Check one) Recipient/Subrecipient: ☒ Vendor: ☐ Exempt Organization: ☐

Comments:

Print Name: Seymour Brown

Telephone Number: (305) 808-6292

Title: Contract Manager

Signature: 

Date: 04/29/10

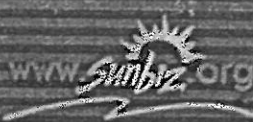
Note it is the program personnel's responsibility to notify Finance and Accounting of which non-state organizations have been determined to be recipients and are receiving state financial assistance (i.e. disbursements must be coded as 7500 object code in FLAIR).

Note it is possible to have a contractual agreement with a non-state organization under Chapter 287, Florida Statutes, and still consider the non-state organization a recipient under the Florida Single Audit Act.

If a recipient/subrecipient relationship exists the standard contract audit language, including Exhibit 1 (DFS-A2-CL), must be included in the document that established the State's, recipient's, or subrecipient's relationship with the non-state entity.

Questions regarding the evaluation of a non-state organization or if it has been determined that the non-state organization is a recipient and a CSFA number has not been assigned, contact your FSAA State agency liaison or the Department of Financial Services, Bureau of Auditing at (850) 413-3060 or Suncom 293-3060.

Reference may be made to Rule 69I-5, FAC.

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Detail by Entity Name

Foreign Limited Liability Company

NATIONAL MENTOR HEALTHCARE, LLC

Filing Information

Document Number M04000005490

FEI/EIN Number 042893910

Date Filed 12/14/2004

State DE

Status ACTIVE

Principal Address

313 CONGRESS STREET
BOSTON MA 02210 US

Changed 04/27/2007

Mailing Address

313 CONGRESS STREET
FIFTH FLOOR
BOSTON MA 02210 US

Changed 04/29/2009

Registered Agent Name & Address

C T CORPORATION SYSTEM
1200 SOUTH PINE ISLAND ROAD
PLANTATION FL 33324 US

Manager/Member Detail

Name & Address

Title MGR

MURPHY, EDWARD M
313 CONGRESS STREET
BOSTON MA 02210 US

Title MGR

FAY, JULIETTE E
313 CONGRESS STREET
BOSTON MA 02210 US

Title MGR

DENIS, HOLLER M
313 CONGRESS STREET
BOSTON MA 02210 US

Annual Reports**Report Year Filed Date**

2007	04/27/2007
2008	04/30/2008
2009	04/29/2009

Document Images

04/29/2009 -- ANNUAL REPORT	View image in PDF format
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Notice of Transaction Fee Exemption

Form PUR 3777 (6/04)

Date	04/29/2010
Agency	APD
Contact Name	Seymour Brown
Contact Email	seymour_brown@apd.state.fl.us
Contact Phone	(305) 808-6296

- Complete this form to exempt a transaction from the Transaction Fee under rule 60A-1.032
- Please retain a copy of this form within your agency for audit purposes.
- Submission of this form to the CSD is not required.

NOTE: Exemption under paragraph (2) of the rule requires DMS approval -- please use form PUR 3778.

TRANSACTION INFORMATION:

Vendor Name : National Mentor Healthcare, LLC/ d/b/a Florida Mentor

Tax Id No. F042893910 Sequence # 001

Master Agreement No.:

Contract No.: KLJ91

Items:

BASIS FOR EXEMPTION:

- Transaction pre-dates effective date of rule 60A-1.031 ☐
- Emergency transaction per rule 60A-1.032(3) ☐
- Categorical exemption per rule 60A-1.032(1) ☐ (Specify below)
- ☐ (a) Procurement under section 337.11, Florida Statutes
- ☒ (b) Procurement under section 287.055, Florida Statutes
- ☐ (c) Procurement under Chapter 255, Florida Statutes
- ☐ (d) Transaction with a non-profit entity
- ☐ (e) Transaction with another governmental agency
- ☐ (f) Transaction with required sole provider or price paid and payee established by federal or private grant
- ☐ (g) Payment to unregistered vendor under Rule 60A-1.030(3)
- ☐ (h) Payment to vendor in exchange for providing health care services at or below Medicaid rates
- ☐ (i) Disbursement to recipient or sub-recipient; payment to satisfy Maintenance of Efforts requirement; or payment to match federal award

Conflict of Interest Questionnaire

National Healthcare, LLC/ d/b/a Florida Mentor
(Title of Solicitation/Contract)

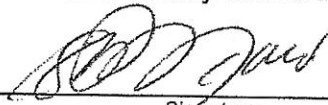
- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Do you, your immediate family, or business partner have financial or other interests in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have gratuities, favors, or anything of monetary value been offered to you or accepted by you from any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you been employed by any potential vendor within the last 24 months? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Do you plan to obtain a financial interest, e.g., stock, in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Do you plan to seek or accept future employment with any potential vendor? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have any other conditions which may cause a conflict of interest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answered "yes" to any of the above questions, please provide a written explanation of your answer below.

I declare all of the above questions are answered truthfully and to the best of my knowledge.

Seymour Brown

Name (type or print)



Signature

5/5/10

Date

Conflict of Interest Questionnaire

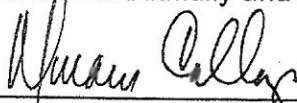
National Healthcare, LLC/ d/b/a Florida Mentor
(Title of Solicitation/Contract)

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Do you, your immediate family, or business partner have financial or other interests in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have gratuities, favors, or anything of monetary value been offered to you or accepted by you from any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you been employed by any potential vendor within the last 24 months? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Do you plan to obtain a financial interest, e.g., stock, in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Do you plan to seek or accept future employment with any potential vendor? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have any other conditions which may cause a conflict of interest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answered "yes" to any of the above questions, please provide a written explanation of your answer below.

I declare all of the above questions are answered truthfully and to the best of my knowledge.

Miriam Collazo
Name (type or print)


Signature

5/6/10
Date

Conflict of Interest Questionnaire


National Healthcare, LLC/ d/b/a Florida Mentor
(Title of Solicitation/Contract)

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Do you, your immediate family, or business partner have financial or other interests in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have gratuities, favors, or anything of monetary value been offered to you or accepted by you from any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you been employed by any potential vendor within the last 24 months? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Do you plan to obtain a financial interest, e.g., stock, in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Do you plan to seek or accept future employment with any potential vendor? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have any other conditions which may cause a conflict of interest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answered "yes" to any of the above questions, please provide a written explanation of your answer below.

I declare all of the above questions are answered truthfully and to the best of my knowledge.

Evelyn Alvarez
Name (type or print)


Signature

5/7/10
Date

Conflict of Interest Questionnaire

National Healthcare, LLC/ d/b/a Florida Mentor

(Title of Solicitation/Contract)

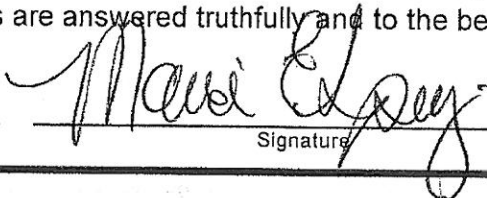
- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Do you, your immediate family, or business partner have financial or other interests in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have gratuities, favors, or anything of monetary value been offered to you or accepted by you from any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you been employed by any potential vendor within the last 24 months? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Do you plan to obtain a financial interest, e.g., stock, in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Do you plan to seek or accept future employment with any potential vendor? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have any other conditions which may cause a conflict of interest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answered "yes" to any of the above questions, please provide a written explanation of your answer below.

I declare all of the above questions are answered truthfully and to the best of my knowledge.

Maria Springer

Name (type or print)



Signature

5/1/10

Date

Conflict of Interest Questionnaire

National Healthcare, LLC/ d/b/a Florida Mentor
(Title of Solicitation/Contract)

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1. Do you, your immediate family, or business partner have financial or other interests in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have gratuities, favors, or anything of monetary value been offered to you or accepted by you from any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you been employed by any potential vendor within the last 24 months? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Do you plan to obtain a financial interest, e.g., stock, in any potential vendor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Do you plan to seek or accept future employment with any potential vendor? . | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have any other conditions which may cause a conflict of interest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If you answered "yes" to any of the above questions, please provide a written explanation of your answer below.

I declare all of the above questions are answered truthfully and to the best of my knowledge.

Kirk Ryon

Name (type or print)

Signature

Date

5/10/16



"Fisher, Jon"
<Jon.Fisher@thementornetwork.com>

06/02/2010 02:29 PM

To Seymour Brown/D11/DCF@DCF

cc "Granda, Estrella"
<Estrella.Granda@thementornetwork.com>

bcc

Subject Florida Mentor

Mr. Brown,

I am dually authorized to sign contracts for Florida Mentor. Attached are our corporate by-laws. If you have any questions feel free to contact me. Thanks, Jon

Jon Fisher
State Director
Florida Mentor
3258 Parkside Circle Tampa Fl. 33619
office (813) 630-1746 ext.27
cell (813) 760-4681

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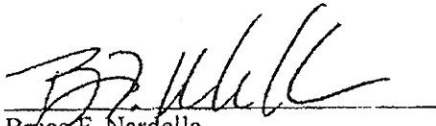
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CERTIFICATE OF AUTHORITY

National Mentor Healthcare, LLC
d/b/a Florida Mentor

I, Bruce F. Nardella, President and Chief Operating Officer of National Mentor Healthcare, LLC, d/b/a Florida Mentor (the "Company"), a limited liability company formed under the laws of the State of Delaware, DO HEREBY certify that Jonathan Fisher, State Director, as duly authorized administrative representative of the Company within the State of Florida, is empowered and authorized to make application for licensure for new and existing services; receive licensing reports; to write, submit and implement plans of correction or otherwise assure compliance with local and state regulations governing service delivery on behalf of the Company within the State of Florida; and to enter into agreements and renewals, amendments and addenda to agreements relating to the Company's provision of services to the State of Florida or any of its agencies, political subdivisions or municipalities, in accordance with resolutions duly adopted at a meeting of the Board of Directors on June 11, 2007, and that such resolutions have not been modified, rescinded or revoked and are at present in full force and effect.

IN WITNESS WHEREOF, the undersigned has affixed his signature this 21 day of June, 2010.



Bruce F. Nardella
President and Chief Operating Officer

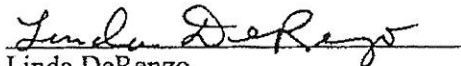
14591

CERTIFICATE OF AUTHORITY

National Mentor Healthcare, LLC
d/b/a Florida Mentor

I, Linda DeRenzo, Senior Vice President and Secretary of National Mentor Healthcare, LLC, d/b/a Florida Mentor (the "**Company**"), a limited liability company formed under the laws of the State of Delaware, DO HEREBY certify that Jon Fisher, State Director, or in his stead, William Allen, Executive Director, as duly authorized administrative representatives of the Company within the State of Florida, and either one acting alone, is empowered and authorized to make application for licensure for new and existing services; receive licensing reports; to write, submit and implement plans of correction or otherwise assure compliance with local and state regulations governing service delivery on behalf of the Company within the State of Florida; and to enter into agreements and renewals, amendments and addenda to agreements relating to the Company's provision of services to the State of Florida or any of its agencies, political subdivisions or municipalities, in accordance with resolutions duly adopted at a meeting of the Board of Directors on June 11, 2007, and that such resolutions have not been modified, rescinded or revoked and are at present in full force and effect.

IN WITNESS WHEREOF, the undersigned has affixed her signature this 10th day of December, 2009.


Linda DeRenzo
Senior Vice President and Secretary